

## 2006- 2007 HUD UNIVERSAL DATA ELEMENTS

Program Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Last Name \_\_\_\_\_ Suffix \_\_\_\_\_

Social Security Number \_\_\_\_\_ or check ( \_\_\_\_\_ Don't Know \_\_\_\_\_ Refused )

1. Service Provided or Need Referred \_\_\_\_\_

2. Service Start Date or Referral Date \_\_\_\_\_ Service End Date \_\_\_\_\_

**(ANSWER THE FOLLOWING IF CLIENT IS PART OF A HOUSEHOLD THAT IS BEING SERVED)**

3.A. Household type: Check one.

- |  |  |
|--|--|
| <input type="checkbox"/> Female single parent                | <input type="checkbox"/> Related caregiver with legal custody      |
| <input type="checkbox"/> Male single parent                  | <input type="checkbox"/> Related caregiver without legal custody   |
| <input type="checkbox"/> Married couple and child(ren)       | <input type="checkbox"/> Unrelated caregiver with legal custody    |
| <input type="checkbox"/> Unmarried couple and child(ren)     | <input type="checkbox"/> Unrelated caregiver without legal custody |
| <input type="checkbox"/> Married couple without child(ren)   | <input type="checkbox"/> Extended Family                           |
| <input type="checkbox"/> Unmarried couple without child(ren) | <input type="checkbox"/> Other                                     |

3.B. Head of Household? Check one. ☐ Yes ☐ No

3.C. What is the Client's Relationship to the head of household? \_\_\_\_\_

3.D. Who is the Head of Household? \_\_\_\_\_

4. Date of birth \_\_\_\_\_

5. Ethnicity (Check one that most applies.) ☐ Hispanic/Latino ☐ Other (Non-Hispanic/Latino)

6.A. Race

- ☐ American Indian or Alaska Native (HUD)
- ☐ Asian (HUD)
- ☐ Black or African American (HUD)
- ☐ Native Hawaiian (HUD)
- ☐ Pacific Islander (HUD)
- ☐ White (HUD)
- ☐ Other

6.B. Secondary Race (Optional)

- ☐ American Indian or Alaska Native (HUD)
- ☐ Asian (HUD)
- ☐ Black or African American (HUD)
- ☐ Native Hawaiian (HUD)
- ☐ Pacific Islander (HUD)
- ☐ White (HUD)
- ☐ Other

7. Gender (Check one.) ☐ Female ☐ Male ☐ Transgender ☐ Unknown

8. Is client is homeless? (Check one.) ☐ Yes ☐ No

9. Is the client chronically homeless? (Check one.) ☐ Yes ☐ No

**Definition of Chronic Homelessness**

*An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. The individual must have been on the streets or in an emergency shelter (not transitional housing) during these episodes.*

10. **Where Did the Client Sleep the Night Before Coming to Your Agency/ Program.** (Check one that most applies.)

- ☐ Place not meant for habitation (HUD) (a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)  
☐ Emergency shelter (HUD) ☐ Permanent housing for formerly homeless persons (HUD)  
☐ Psychiatric hospital or facility (HUD) ☐ Substance abuse treatment center (HUD)  
☐ Hospital (non-psychiatric) (HUD) ☐ Jail, prison or juvenile detention facility (HUD)  
☐ Rental House/Apartment (HUD) ☐ Homeownership or Condo Ownership (HUD)  
☐ Living with family (HUD) ☐ Living with friends (HUD)  
☐ Hotel /motel/ SRO ☐ Foster care home or foster care group home (HUD)  
☐ Domestic Violence Situation ☐ VA Contracted Halfway Program  
☐ Non-VA Contracted Halfway Program ☐ Other (HUD)  
☐ Don't know (HUD) ☐ Refused to answer (HUD)

11. **How Long Did the Client Stay in the Place They Were Prior to Entering Your Agency/ Program?** (Check one that most applies.)

- ☐ One week or less ☐ More than three months but less than one year  
☐ More than one week but less than one month ☐ One year or longer  
☐ One to three months

12. **Zip Code of the Last Place Client Lived for 90 Days or More** \_\_\_\_\_ or check ( ☐ Don't Know ☐ Refused )

**To Determine the Percentage of the Clients County Median Income (CMI), Answer the following questions:**

- 13.A. **How Many Individuals Are in the Client's Household?** 1 2 3 4 5 6 7 8  
 13.B. **In What County Does the Client / Household Live?** \_\_\_\_\_  
 13.C. **What Is the Household's Annual Income?** \_\_\_\_\_ or check ( ☐ Don't Know / ☐ Refused )

14. **Is Client US Military Veteran?** (Check one.) ☐ Yes ☐ No ☐ Don't know ☐ Refused

17. **Does the client have a disability of long duration?** ☐ Yes ☐ No ☐ Don't know ☐ Refused

18. **If the Client Has a Disability, Check All that Apply and Provide a Date for which the Disability Began if Known and Ended if Known.**

<u>Check</u>	<u>Disability Type</u>	<u>Start Date</u> Fill In Only If Client Knows the Date for which the Disability Began	<u>End Date</u> Fill In Only If Disability Ends While Client is Receiving Service
<input type="checkbox"/>	Alcohol Abuse		
<input type="checkbox"/>	Drug Abuse		
<input type="checkbox"/>	Developmental		
<input type="checkbox"/>	Physical/Medical		
<input type="checkbox"/>	Mental Illness		
<input type="checkbox"/>	Physical/Mobility Limits		
<input type="checkbox"/>	HIV/AIDS		